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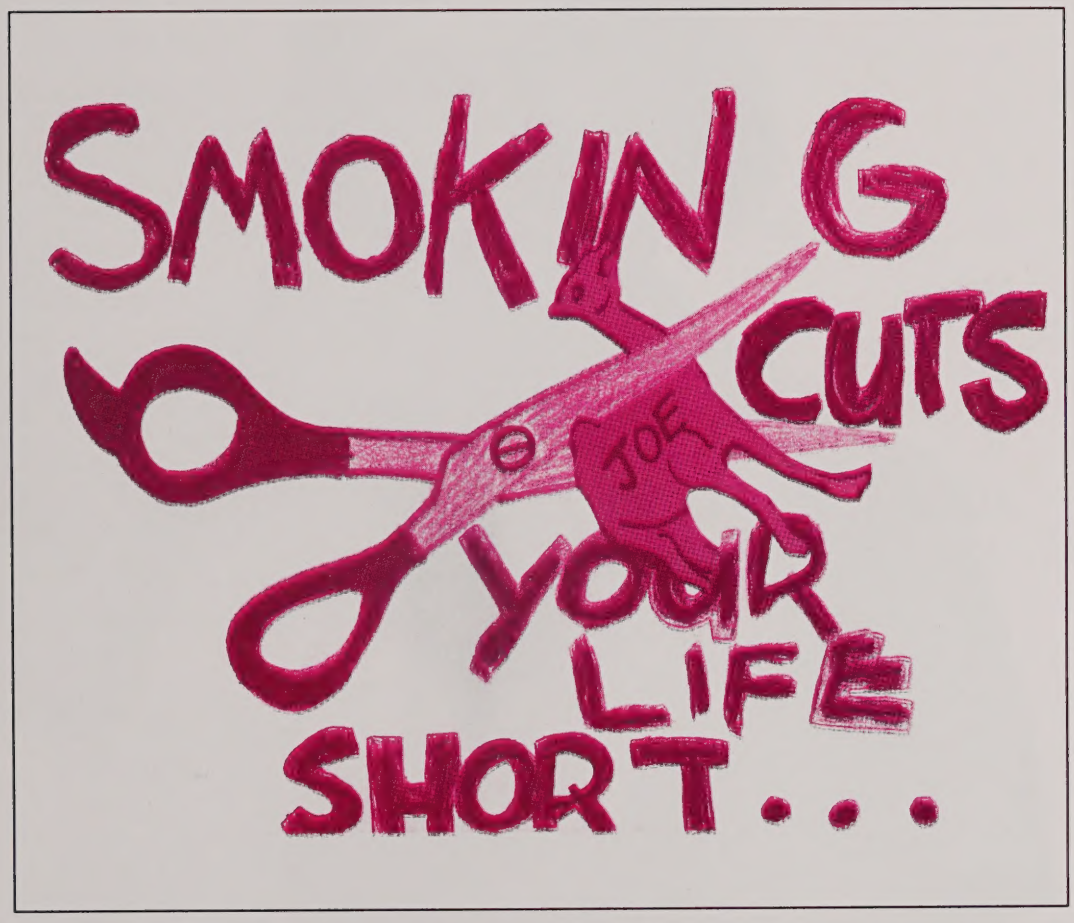

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THE
Hampden Hippocrat
SUMMER 1995

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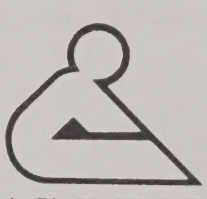
From The Editor

This summer issue of the *Hampden Hippocrat* has an essay on quality in health care from a physician's personal perspective. We also cover the address by Representative Carmen Buell at the HDMS Annual Meeting. Dr. Betsy Brooks has written a brief for the Children's Medical Security Plan. I have covered the national ethics symposium that was held at the VA in Northampton in April 1995.

Beginning in September, 1995, the *Hippocrat* will publish quarterly as decided by the Executive Committee. Dr. Dennis Gordan of Weldon Rehabilitation Center has joined the Editorial Board. Writers are encouraged to submit articles of clinical or topical interest by August 15, 1995.

Brigid Glackin, M.D.
Editor



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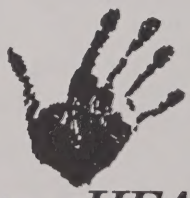

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Hampden Committee Activities

The Medico-Legal Committee met in March to begin planning for the Fourth Annual Forum to be held on November 2, 1995. The topic will be "The Medical-Legal Consequences of Health Care Reform". The Committee is also working on finding a solution to the problem of a physician being subpoenaed to give a patient's medical record up to the Court when the patient has not given their written approval to do so. Hospitals have a statement in place which protects them in this type of a situation. Perhaps something similar could be drawn up for physicians utilizing special legislation if necessary.

The Public Health Committee met in March and April. Dr. Riley discussed a Smoking Intervention Workshop he attended sponsored by the Massachusetts Medical Society and UMass. Dr. Riley also attended a training session at UMass Medical School and is now able to present a program to physicians on how to stop their patients from smoking. He reported that smoking results in 22% of heart disease cases, 87% of lung cancer cases, and 82% of chronic lung disease cases. Of 500 adult patients, 26% will be smokers. If a doctor spent only 2 to 3 minutes talking with a smoking patient, you could estimate that 6% or 8 people would stop smoking as a result of that talk. Dr. Riley will present his program in area hospitals in the near future.

The Executive Committee met in March and April. Annual committee reports were approved as well as the Nominating Committee Report presented by Dr. Malladi. Discussion at the April meeting focused on the future plans for the Hampden Hippocrat. Our invited guest was Mr. Paul Giorgio of Worcester Publishing in Worcester, MA. His company currently publishes "Worcester Medicine", which is the magazine of the Worcester District Medical Society. Mr. Giorgio outlined changes that would have to be made. He also had some great suggestions which would improve the quality and content of the magazine.

One hundred members, spouses and invited guests attended our Annual Meeting held at the Storrowton Carriage House on April 25, 1995. The membership thanked Dr. Alicia Ross as the outgoing President and welcomed Dr. John Papale, who will serve as President this year. Our speaker for the evening was State Representative Carmen H. Buell. Representative Buell gave an update on the Health Care Reform Agenda. Her presentation was very informational and generated a lively question and answer period.

A Legislative Breakfast was held on March 31, 1995 at Mercy Hospital Deliso Center. Topics discussed were the Children's Medical Security Plan, Managed Choice, Public Disclosure by Health Insurers, Non-Discrimination Standards for Physician Contracts, and Shared Liability for Injuries Associated with Utilization Review Activity. Legislators attending were Senators Michael Knapik and Brian Lees, and State Representatives Valerie Barsom, Paul Caron, and Anthony Scibelli. Aides attended from the offices of Senator Linda Melconian and Representatives Cele Hahn, Dennis Murphy, Thomas Petrolati, Mary Rogeness, and Ben Swan. The Legislators urged the physicians to keep in touch with them throughout the year concerning any issues that they feel are important. ■

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Smoke And Mirrors

In 1992, the voters of Massachusetts approved an initiative to increase the cigarette excise tax by 25 cents per pack. Subject to legislative appropriation, the proceeds from the tobacco excise tax was stipulated to be used to reduce tobacco use in the state. With the passage of the initiative it was generally felt that we were finally headed in the right direction. The Massachusetts Tobacco Control Program was started in 1993.

Alicia O. M. Ross, M.D., President

It was well known that cigarette smoking is the leading cause of preventable death and disease in the state, therefore educating the public about the devastating effects on one's health became a prime purpose of this program. Through a collaborative effort of the Hampden District Medical Society, the American Cancer Society, The American Heart Association, and the American Lung Association, the "Smoke-free Class of 2000" was created. The goal is to have a tobacco-free society by the year 2000 by reaching children before they become smokers. With funding from the Massachusetts Tobacco Control Program and some outside underwriting, the Hampden District Medical Society sponsored a poster contest for third graders in Springfield schools. The contest emphasized awareness of the consequences of smoking and promoted positive attitudes towards a smoke-free environment. The goal was to counter the effects of cigarette advertising targeting young people. This contest has now expanded to the public and private schools of both the Hampden and Hampshire Districts.

Another project funded by the Massachusetts Tobacco Control Program is the effort to eliminate smoking in restaurants. The American Cancer Society and its volunteers have worked hard for ordinances which would prohibit smoking in restaurants in the Hampden and Hampshire counties. After the ordinances were passed many restaurants responded positively to the ban. However, the cigarette manufacturers have exerted heavy pressure to have the ordinances reversed. They were able to convince some restaurant owners to resist the smoking ban. These short-sighted businessmen do not realize that healthier customers and employees will improve their bottom line in the long run.

The Massachusetts Tobacco Control Program has had some noteworthy successes: cigarette sales has decreased by 15 percent across the state

in the last two years; implementation of tobacco control programs has been funded in over 200 towns and cities; almost every public school in Massachusetts has received funds for comprehensive school health education which include a significant tobacco control component; two hundred and forty-five D.A.R.E. (Drug Abuse Resistance Education) programs were provided funds to work with local retailers to prevent sales of cigarettes to minors. A telephone Smokers Quitline was created to answer questions and encourage those who want to quit smoking. A specific brand of cigarettes targeting minorities has been forced out of Boston.

The tobacco industry has not given up. It has used its seemingly unlimited funds to pressure the Massachusetts legislature, which has now reduced funding for the Tobacco Control Program. Cigarette manufacturers target children with advertisements containing illusions of smoking as being cool and healthy. These fanciful advertisements can be seen at ethnic festivals, sporting events, and concerts which cigarette manufacturers sponsor. Billboards with cigarette advertisements are strategically located in ethnic neighborhoods. Free packs of cigarettes are distributed indiscriminately on city streets, and coupons for free cigarettes are mailed to residences all over the state.

The Massachusetts Tobacco Control Program is not yielding. Every method used by the tobacco industry is countered by a similar method to deliver information about the poisonous effects of tobacco. The lawmakers must restore funding to the Massachusetts Tobacco Control Program if they truly want to save health care dollars in Massachusetts. We can help. We can educate our legislators about the tremendous costs of smoking-related health problems, diseases, and deaths. All it takes is a telephone call, a telegram, a letter, or a fax to your legislators to help blow away the smoke and mirrors of misinformation produced by the tobacco industry. ■

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In Memoriam

John J. Driscoll, M.D., 87, of Holyoke, a city physician for more than 50 years and a grand marshal of the Holyoke St Patrick's Parade in 1960, died at home on March 10, 1995.

Dr. Driscoll began his private medical practice at Sonoma Place in Holyoke in 1938 and was named the first chief of staff at Providence Hospital here in 1970. He also served as the city physician in 1940-1941. After World War II he moved his practice to Elm Street.

He was past president of the Providence Hospital staff and served on many hospital committees. He was a member of the Hampden District Medical Society, the Massachusetts Medical Society and the American Medical Association.

He was born in Montville, CT and moved here at a young age. He was a 1925 graduate of Holyoke High School and was also graduated from the University of Detroit in Michigan. He received his medical degree from Tufts Medical School in 1937 and completed his internship at Providence Hospital.

He was a Navy veteran of World War II and served in the Pacific Theater from 1942 until 1946 with the rank of lieutenant commander.

A lifetime member of the St. Patrick's Committee, he received a distinguished service award from the committee March 4 of this year for his many years of service, commitment and dedication to the event. He has also received the George E. O'Connell Award in 1973. He was an originator of the annual Colleen Coronation Ball, which began in 1960.

He was instrumental in obtaining the presence of nationally known persons of Irish descent for the parade and in the selection of recipients of the parade's annual John F. Kennedy Memorial Award. He became friends with a number of those recipients, including the late actors Pat O'Brien and Bill Gargin.

He was a fourth-degree member of the Knights of Columbus and was a member of the ancient Order of Hibernians. He was a communicant of Holy Cross Church.

He leaves his wife, the former Dorothy Sweeney; a son, attorney John J. of Holyoke; six daughters, Judith Hohol and Bridget Walczak of Holyoke, Deborah Driscoll of Franklin, Mary Hilliard of Atlanta, GA, Katherine Stratton of Roslindale and Anne Driscoll of Martinez, CA; and 10 grandchildren.

Memorial contributions may be made to the Betty and George Ross Nursing Scholarship Fund, in care of Margaret Lucey, 3 Yale St., Holyoke, MA 01040. ■

"The Right To Die"

On Tuesday, April 18, 1995, the Department of Veterans Affairs and its Ethics Advisory Committee presented a national symposium on "The Right to Die?" at the VA Medical Center in Northampton, Massachusetts. This conference was transmitted by satellite to 135 other VA sites with questions available from those audiences. Keynote speaker was C. Everett Koop, M.D., former U.S. Surgeon General and currently Senior Scholar at the C. Everett Koop Institute at Dartmouth. Other participants included George Annas, J.D., M.P.H., Chair of the Health Law Department at Boston University; Alexandra Beckett, M.D., Director of the HIV Psychiatry Service at Beth Israel Hospital in Boston; William Nelson, Ph. D., Co-Director of the VA National Center for Clinical Ethics at White River Junction; David Law, M.D. from the National Clinical Director's Office of the VA, and Herbert Hendin, M.D., Director of the American Suicide Foundation at New York Medical College.

Dr. Koop spoke initially after giving a press conference in which he declared Dr. Kevorkian to be a "Serial Killer". He then gave his address and fielded some audience questions, but did not remain to engage in any debate with the other panel members, some of whose views were divergent from his own He was at once a superb "communicator" able to present his views in a pithy, affable way, ideally suited to contemporary media coverage. He was at the same time imperious, iconoclastic and unwilling to engage intellectually with the audience.

Dr. Koop expressed concerns about the integrity of the medical profession in light of recent discussions of assisted suicide. He stated that in 1973, at a commencement address at Wheaton College, he warned that the legalization of abortion would cause the moral fiber of the society to erode and would lead inevitably to infanticide and euthanasia. He feels that this prediction has come true. He noted the essay in the *New England Journal* by Dr. Quill regarding assisted suicide. In Oregon legalizing assisted suicide has been passed with similar bills pending in Connecticut, Massachusetts, New Hampshire, and Maine.

Dr. Koop expressed concerns about the integrity of the medical profession in light of recent discussions of assisted suicide.

Dr. Koop's principal argument against physician assisted suicide was that it violates the Hippocratic Oath, "I will never use treatment to cause injury." He made the argument raised at The Medical Religious Committee lecture of the HDMS last fall that the separation of killing and healing in Greek civilization represented a sign of the advancement of society from the primitive. He recommended that patients in intractable pain be made as comfortable as possible and then "let nature take its course." He agreed with discontinuing therapy to eliminate the pain and suffering of therapy itself. He supported not prolonging the act of the patient's dying. He felt that physicians who would be aggressive in this area had been "captured by the argument of self determination" and their efforts were attempts to make death "simple, certain, and predictable."

Requests for rational suicide are a symptom of the patient's depression in Dr. Koop's view. Opening up such a discussion with a patient may lead to requests for assistance based on dissatisfaction with the patient's current situation in life. The values involved become those of the physician's rather than the patient's. Doctors regularly withdraw from dying patients, withhold pain medication and underestimate the quality of life. Dr. Koop opined that eliminating pain by eliminating the patient is like destroying the village to save it. If the ultimate value is to kill anyone who suffers then the irreversibly comatose would be excluded because there is no self determination

and no suffering. Dr. Koop expressed the view that euthanasia should be called "patient assisted homicide." He said that the unspoken point of this killing is to relieve stress on physicians who have to deal with dying patients.

Dr. Law

Dr. Law of the VA National administration then gave an overview of the VA system . It is the largest unified health care system in the world. Fifty-eight is the median age of the patients. The fastest growing group of veterans cared for is age 75-90. The VA system currently recognizes *futility*. It recognizes the right of physicians not to participate in therapy they feel is futile, but not to perform therapy they feel is unethical. Medicine at the VA is governed by federal statutes only–no state regulations apply. Dr. Law feels the debate will be more productive if terms are better defined. He notes that patients may refuse all medical care and that they may refuse specific treatments in a medical setting. He also feels ethnicity issues must be addressed. Non-Hispanic whites consistently show a greater acceptance of withholding treatment than Blacks or Hispanics. There is no unanimity among physicians. Ninety per cent of physicians approved withdrawal of tube feeds in a study in patients with severe dementia needing restraint to feed. *Fifty per cent* approved of *starting* tube feeds in the "happily demented." Physicians as a group adapt to specific situations, rather than rigidly holding to ethical principles.

Dr. Hendin

Dr. Hendin spoke from his perspective as a psychiatrist who treats suicidal patients. He has also done research in suicide and has studied the experiment in the Netherlands with doctor assisted suicide. He asked, "Does our need to care for the terminally ill *require* that we legalize assisted suicide?" He feels that suicidal patients make conditions that life cannot provide and state that life is only worth living if certain conditions can be met. This activity, he feels, distracts from the fear of death itself. This fear may be different than the fear of suffering in the last days of life.

He notes a sequela of the Netherlands experience has been the expansion of euthanasia to the chronically ill. An independent review of the Netherlands experience found 1,000 cases in two years of ending the patient's life without specific request. In 20% of these cases the patients were competent. The intention of the Netherlands'

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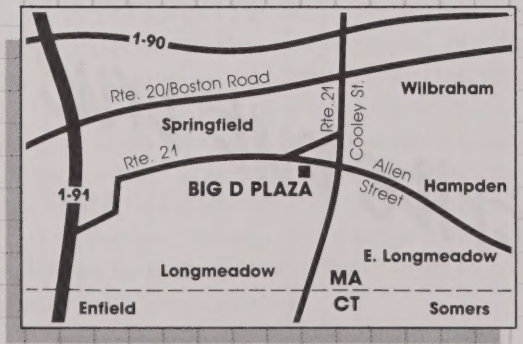

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The Right To Die

Continued from previous page

program was exceptional cases, but the practice has become a routine way to deal with terminal or serious illness. Dr. Hendin feels this is fueled by a "Messianic conviction of good being done." It is an exercise of the will of the doctor and the relatives and their perceived right to end a life not worth living. The physician has the illusion of mastery over the disease. At the same time, there is the fiction that the doctor is the uninvolved facilitator.

The National Commission on the Care of the Terminally Ill has concluded that the practice of using advance directives hasn't fulfilled our expectations. The guidelines established are not binding. The key issue for physicians is to decide in specific cases should they set in motion the technology that prolongs life. Physicians need to learn how *not* to do this.

Dr. Annas

Dr. Annas spoke from his perspective as a lawyer who talks to and teaches doctors. He reviewed a suit brought in Washington state by an organization called Compassion in Dying. They argued that patients have the right to refuse treatment and that this is equivalent to suicide. This lower court ruling was overturned by the 9th Circuit Court of Appeals March 9, 1995. The court stated that you can't get carried away with emotional identification with terminally ill patients. The right to refuse treatment is based on the old notion of privacy. It is not the same as the right to consent to be enslaved or mutilated. Equal protection does not require that you give doctors the right to give lethal drugs to competent people, the court ruled. If it did, then it would be a denial of equal protection if not extended to incompetent people. This ruling is currently being appealed to the Supreme Court by Compassion in Dying.

Current law is that a doctor can provide drugs to patients as long as patients do not have a current intent to kill themselves and the doctor does not intend to kill the patient. Dr. Quill was right then, by this standard, if he believed the patient would live longer and better if she had these lethal drugs in her possession.

Dr. Annas responded to questions later about why there are so many lawyers on hospital ethic committees. He argued that "the law is the floor below which we cannot sink". He agreed that moral or ethical standards may be higher than legal ones.

Dr. Beckett

Dr. Beckett spoke of her experiences as head of the HIV Psychiatry Service at Beth Israel Hospital in Boston. She noted that in psychiatry the wish for death is seen as a psychopathological condition that will disappear with treatment. Suicidal individuals are confined because it is assumed that they will benefit from treatment. The vast majority of cases can be helped with medical, psychiatric, and spiritual intervention. These are the easy cases in Dr. Beckett's view.

Doctors, when surveyed, state that they personally want access to lethal drugs for themselves at the end of their lives if life becomes too painful. The patient's fear of treatment and overtreatment is driving requests for less treatment and ultimately for assistance in dying. Patients fear loss of independence and they fear degradation in Dr. Beckett's experience. Physicians are hampered by being unable in many cases to predict the outcome of technological intervention.

Dr. Beckett feels that the wish for death is not necessarily pathological. Psychiatry cannot treat all depression. Christine Casals has suggested that there needs to be a context in which death is not the enemy. The refusal to deal with the personal meaning of life and death for the patient reflects how sterile and technological the practice of medicine has become.

Dr Beckett notes that suicide rates among HIV and AIDS patients are rising. The practice of assisted suicide is going on surreptitiously. A report from Vancouver suggests that over half of the cases are botched. Patients ask friends to cover their heads with a plastic bag if death does not occur six hours after an overdose. Post traumatic stress disorder is seen in persons who assist. Dr. Beckett presented a very moving case of a nurse with AIDS who after horrendous suffering with unremitting diarrhea and painful herpes, sought death to spare her teenage daughters seeing her demented and degraded. She also wanted to spare them further impoverishment. Dr. Beckett feels we will still encounter cases of *realistic hopelessness* where interventions will not be helpful. The world is far messier than the academics allow for and that gap troubles all of us. Dr. Beckett does not believe in "rupturing the doctor patient relationship in the service of an absolute righteousness." "What is the point if at the very moment of the patient's greatest need the doctor is not there to work with him?" she asks.

Dr. Nelson

Dr. Nelson believes that there is a limitation on the patient's autonomy when it involves the actions of other people. Forty-four states *prohibit* assisted suicide. He supports the patient's right of refusal of or withdrawing of extraordinary and even ordinary treatment. He feels we need to understand the distinction between refusal and requesting suicide. He feels it is a major leap from the individual decision for suicide to a policy or law. He feels the focus should be shifted to enhancing the quality of life for chronically and terminally ill. He suggests: 1). an increase in knowledge on all aspects of palliative management for physicians; 2). increased communication between physicians and the chronically ill; 3). universal comprehensive health care including palliative care be legislated prior to assisted suicide. ■

Suggested Reading

1. Johannes J. M. van Delden, Loes Pijnenborg and Paul J. van der Maas, "The Remmelink Study: Two Years Later," Hastings Center Report 23, no. 6 (1993): 24-27. A follow up on medical decisions at the end of life in the Netherlands.

2. Koop, C. Everett. "The Challenge of Definition" from the Proceedings of the International Conference on Euthanasia and the Future of Medicine. Clark University, Worcester, MA, 24 October, 1988. Walter Wright and Patrick Derr (editors).

3. Annas, George J. "Death by Prescription" NEJM vol 331, no 18 1240-1243, 1994.

4. Gregory, Dorothy, Nelson, William et al "Futility Guidelines: A Resource for Decisions about Withholding and Withdrawing Treatment", VACO Bloethus Committee NCCE News Supplement, Summer, 1994

5. Hendin, Herbert "Scared to Death of Dying". The New York Times Op-ED December 16, 1994.

6. Beckett, Alexandra and Doublas Svenson "Suicide Risk in Patients with Human Immune deficiency Virus Infection and Acquired Immune deficiency Syndrome. Harvard Review of Psychiatry, Vol. 1, no 1 27-35, 1993.

7. Nelson, William and James L. Bernat "Decisions to withhold or Terminate Treatment" Ethical Issues in Neurologic Practice, Neurologic Clinics, Vol7, No. 4: November, 1989 pg 759-774.

The transcript of the entire conference is available on audio tape. Contact David Schwartz at the VA Medical Center in Northampton.

Children's Medical Security Plan

Dr. Betsey Brooks, of Holyoke Pediatrics, gave the following address to an audience of Massachusetts Legislators and Physicians at the annual legislative breakfast, March 31, 1995.

As a pediatrician with 10 years of practice experience and as a member of the executive committee of the Massachusetts Academy of Pediatrics, I come here to endorse the Children's Medical Security Plan and to urge increased funding to open it for new enrollees.

The Children's Medical Security Plan is a program designed to provide basic health care to the children of low and moderate income families who do not have other access to health insurance.

Child poverty is a growing problem. Nationally, almost one in four children live in a family with a family income below the poverty level. Among minority children one in two live in poverty. Although the fraction of children in Massachusetts living in poverty is less then the national average, many children in our state live in poor or near poor families. There are approximately 90,000 children in Massachusetts without any health insurance. Affordable health care and access to health services are especially important to low income families. As the national debate shifts from how to provide universal health care to how to reform welfare, I expect that we will see growing number of poor and near poor children losing their access to health care.

The Children's Medical Security Plan is designed to meet basic health needs for children in low income families. Among the working poor many parents have insurance plans that don't cover their children or have only very limited coverage. Historically most health insurance plans are designed for adults, and cover the high cost procedures and inpatient care that adult patients need. Children's needs are different. Most children will not require hospitalization, but will benefit from insurance that covers primary and preventive care such as immunizations, developmental monitoring and office sick visits. These services are relatively inexpensive, but for low income families the cost may be prohibitive.

There are approximately 90,000 children in Massachusetts without any health insurance.

The Children's Medical Security plan is designed to meet the basic health care needs of children. It targets basic outpatient and preventive care and limits benefits for inpatient care, costly procedures and medications. It provides free insurance for young children in families with incomes up to 200% of the poverty level and inexpensive coverage for children from families up to 400% of the poverty level. The benefit package is not comprehensive, but it includes cost effective basic services. The benefit package provides basic primary care services, including immunizations, unlimited sick care visits in a doctor's office, first aide treatment, minor office surgical procedures. It includes limited outpatient surgery, emergency room coverage up to $1,000 per year, and an annual pharmacy benefit capped at $100 per year.

The value of this program is great. Enrollment opened in July 1994 and because the demand for services was so great, it was closed in November of 1994. At that time funding was exhausted and new enrollees could not be accepted. Enrollment grew from 11,000 to 22,000 in the five months the program was open. Due to funding limitations the program is not currently open for new enrollees.

Every day in my office I see kids who either already benefit from this program or who could. This week I saw a young mother whose child came to the office with moderately severe asthma. The child was covered by the CMSP. We were able to treat the child with aerosolized asthma

medications, and set the child up with a machine for home treatments. If the child had not had health insurance, this young mother might have delayed seeking treatment, and the child would have needed an expensive emergency room visit and probably hospitalization. I daily see children from working near poor families whose parents do not seek cost effective immunization because of the out of pocket expense. Remember, each dollar spent immunizing children saves 8 to 12 dollars in health care costs. Through the Children's Medical Security Plan, the average healthy child would have all of his or her preventive care covered, avoiding unnecessary suffering, illness, and future expenses. Children with more complex medical problems might exhaust the limited benefits in the plan, but it would have afforded the child's entry into the health care system. The physician could explore other ways not provided by the plan to provide medically necessary care beyond the scope of the plan's basic coverage.

Children are our future. As a nation we have made a pledge that all elderly people will have access to health care. Many children do not have financial access to even basic health care. It is far less expensive to provide basic care to children then to provide it for the elderly. The benefits of primary and preventive pediatric care accrue over a child's lifetime. We need to ensure that all children have access to basic health care services including preventive care and immunizations. As AFDC benefits are restricted and more parents work at jobs that do not provide good health insurance for their children we need the safety net that this program provides for some of our most vulnerable children.

We at the Massachusetts Chapter of the American Academy of Pediatrics would like to thank you for your support in making this valuable program a reality. We would also like to urge you to expand the program in the following ways:

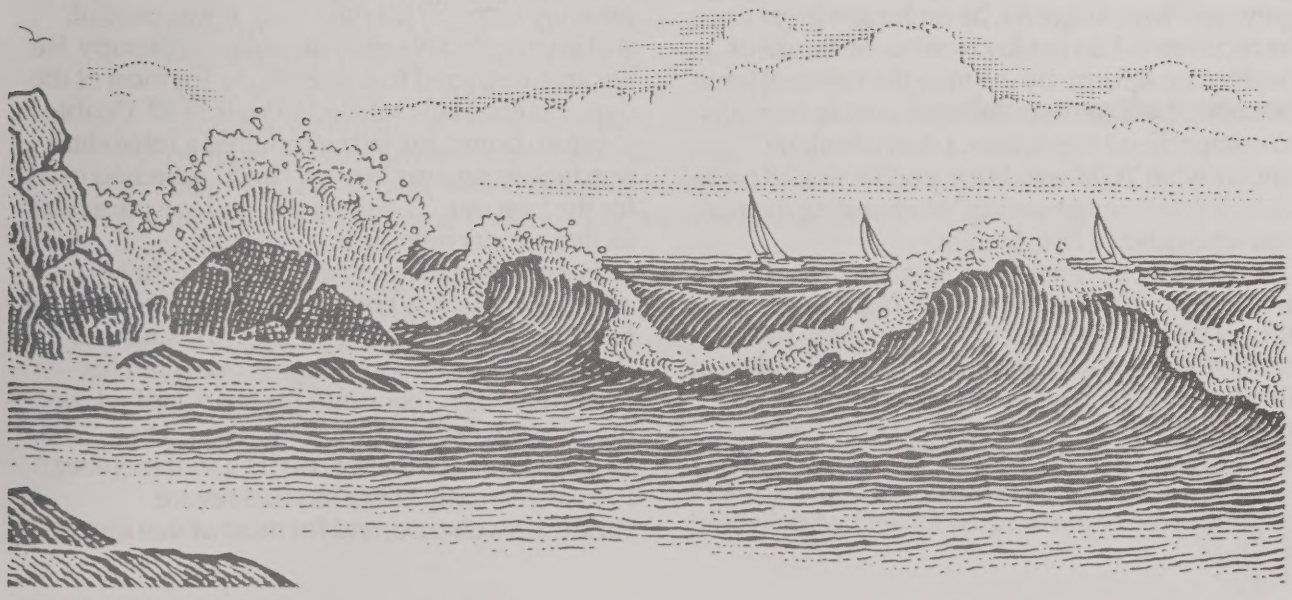
1. Expand funding so that this program is available to all children who meet eligibility requirements.

2. Expand coverage from age 12 to age 18 or 21. Currently the program covers children from birth to age 12. Children aged 12 to 21 are also in need of basic health services. Chronic disease management, well child care including immunization, diagnosis and treatment of substance abuse, and contraceptive counseling and care are basic health care needs of children in this age group. We must make sure that these services are available to youth from low income families.

3. Expand and reorganize the pharmacy benefit. Currently the pharmacy benefit is set at $100 per year, a level that does not cover the usual childhood illnesses. Provisions that do not require large out of pocket expenses would make this benefit more helpful to very low income families who do not have the cash to put forward for medication pending reimbursement.

The Children's Medical Security program is a very valuable program. With your help, we can make it even better. ■

Betsy Brooks, M.D.



Quality Comes Home

1994 National Forum Plenary Address. Donald Berwick, M.D., President and CEO, Institute for Healthcare Improvement.

Never before in the recent history of health care on this continent has common sense been so uncommon. I feel as if I am watching an ant hill on which some passing hoof has trodden. So much scurrying. But to what end? To what purpose? To become what? Deming made "constancy of purpose" the first and most crucial of his fourteen points. Today, "constancy" seems farthest from our minds.

Never before in the recent history of health care on this continent has common sense been so uncommon.

Quality came close to home for me as an issue this year. I was reminded with unwelcome vividness what constancy we really need—what, behind the chaos of mergers and acquisitions, downsizing and layoffs, budget cuts and price slashing, integrating and competing, is worth the trouble. It involved my father.

My father is a retired physician in rural Connecticut. For 42 years, he provided care as a general practitioner in the tiny town in which I grew up. Now, at age 84, he no longer gives care; he receives it. I do not know what he thinks of health care reform. By the time the national issue became popular, my father was unable mentally to comprehend the debate. I don't think he knows what TQM stands for, and he would probably define "reengineering" as changing the person who drives a freight train.

Of course, he does know quality. He is the guy who got up in the middle of the night because Jimmy had a high fever, or Mr. Bernstein had a heart attack, or there was an awful car accident at the drawbridge. I heard him rude sometimes to patients, but never unconcerned. And, when I attended my 30th high school reunion this year, I was still Dr. Berwick's boy. People could not wait to remind me of the time my father had delivered their baby, or themselves, or sewn a wound or answered a tough question. Not a great doctor, perhaps; but a good one. He was always there, they said. You could count on him.

My father retired ten years ago, and not long afterward began developing symptoms of Parkinson's disease and mild dementia from small, multiple strokes. He remained alert, but became progressively weaker until he fell at home and broke his hip this past June. His housekeeper found him, and called the ambulance.

My brother, who lives an hour from my father's home, rushed to the local hospital to meet him in the Emergency Room. He was told—in error—that my father was not there. Panicked phone calls followed as my brother searched anxiously for my father's whereabouts until, finally, someone alerted him that my father was there, after all, and was about to be wheeled into the operating room.

Postoperatively, my father lay sedated on a special mattress with sections alternating in inflation and deflation. Within a week, he had a deep pressure ulcer on his right heel. It was painful, and interrupted his early ambulation therapy. He became restricted to a wheelchair for most of the day, and gradually refused to walk at all. Unable to return home, my father required a rehabilitation facility, and my brothers and I searched hard for the best one. The signs pointed to a particular facility twenty miles from his home.

I visited him there on the morning after his admission. He was lying stuporous in the bed, on his back, with his ulcerated heel pressing into the sheets. His mouth was hanging open and his eyes were rolled back into his head. I asked the nurse for an explanation. "We sedated him," she said. "He was combative. He hit a staff member." For ten years, my father has had severe Parkinson's disease, and for most of that time he

has been unable voluntarily to extend his own arm, much less throw a roundhouse punch. My father had undoubtedly been angry, yes. But a punch... No. I demanded that the sedation be stopped.

Not that it mattered much. For reasons that never became clear, his Parkinson's medication, meticulously adjusted for two years by his doctor at home, was summarily stopped upon entry to the nursing home, resulting in a two week siege of spasm and much decreased mobility.

Not that that mattered. By now the pressure sore on his right heel had opened again, causing pain that prevented him from walking or even spending much time in a wheelchair.

Not that that mattered because when my brothers and I asked that my father be placed in a wheelchair whenever possible, the weekend shift of nurses told us that no wheelchairs could be found, and they asked if we could bring in his rickety old wheel chair from home. Eventually, they did find a wheelchair, although it was missing the footrest plate that would otherwise have protected his injured heel from further bruising.

He spent six weeks in the rehabilitation facility, and gave up—as did they. He returned home to a hospital bed and round-the-clock house keeper coverage. Two weeks after he got home—now almost entirely bedridden and almost certainly never to walk again—a wheelchair finally came. The latest model, with postural supports, custom back rests, and hand controls he can never use. It's beautiful. The price: $6,000. It sits proud and nearly totally unused in the corner of his bedroom.

It is very hard to convey to you the special sense of helplessness that I feel as a participant in this. One year ago, I stood before 1,500 National Forum attendees in Orlando to set an agenda for improvement. I proposed 11 Aims for clinical leadership of change that really would matter. Aim 5 asked for more appropriate use of pharmaceuticals, especially in the elderly. But I find my own father heavily oversedated with sleeping pills he does not need and dramatically undermedicated with the anti Parkinson agents that he does need.

Aim 8 was for the appropriate use of technologies, especially in the last stages of life. But I find an excessively complex and nearly useless $6,000 wheelchair freighted to my own father's home, when a far simpler one could not be found during the week in which it would have

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Quality Comes Home

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made a real difference. Aim 7 asked that we decrease waiting. But my own brother sits uninformed and confused for too long in an emer gency room waiting area. Aim 2 involved prevention, including prevention of injuries, but my own father, inevitably, falls at home. And, inevitably, he acquires a debilitating and totally preventable pressure ulcer that interrupts his rehabilitation irreversibly. I feel helpless. So does he.

Yet, behind this story, and beyond the anger, I feel a sense of possibility. In the course of my work, I am privileged to see good news as well as bad. Time after time, in place after place, I see throughout the health systems of the U.S. and Canada an ever-increasing collection of glowing successes that rivet my attention. Let me show you some examples:

My father was oversedated; it did not need to be that way. At Intermountain Health Care's LDS Hospital, the Director of Critical Care Medicine, Terry Clemmer, the Nurse Manager of that unit, Vicki Spuhler, and their colleagues have worked for two years on safe sedation, substituting for new, expensive drugs a class of older, safer, and less costly agents. Total savings for IHC have been $209,000, with far safer levels of sedation for the ICU patients.

Ken Peterson and his colleagues in pediatrics at the Alaska Native Medical Center in Anchorage have been working on improvements in sedation of children for CT scans, and have reduced the need to reschedule procedures because of ineffective sedation from a rescheduling rate of 40% in May, 1993 to under 1% in September, 1994.

Medication improvement has been an aim of the infectious disease group at LDS Hospital since the mid-1980s. And for their work over the past six years, they show antibiotic costs down almost $200,000 per year, with a decrease in antibiotic costs from 46% of the pharmacy budget to 13%. Duration of therapy has fallen, along with the proportion of patients on antibiotics at all, with improving outcomes from infections.

My father was never successfully rehabilitated from his hip fracture because the rehabilitation system failed him at crucial points. It didn't need

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to be that way. Bill Nugent, Chair of Cardiovascular Surgery at Dartmouth, and his team have reduced both median postoperative length of stay and mortality rates from heart surgery through careful preparation of patients for postoperative care and rehabilitation.

Michael Morris and Peter Mandt, Orthopedic Surgeons at Virginia Mason Medical Center's Sports Medicine Clinic, have redesigned their repairs of anterior cruciate ligaments tears. Between 1993 and 1994, they have reduced actual costs of care by almost $1,500 per patient, from $4,501 to $3,031, while sustaining clinical success rates of 96% and return to work at one year of 100%.

My father's rehabilitation was irreversibly stalled by a pressure ulcer on his foot. It did not need to be that way. Pressure ulcer prevention has been the object of a major guideline effort of the Agency for Health Care Policy and Research. That work was studied and used by a team at LDS Hospital, under the leadership of Carol Ashton, who is now able to celebrate a decline in ulcer rates on a medicine service from 24% in the period July to December, 1992 to 7% in January to June, 1993. For the highest risk patients, ulcers fell from 37% to 10% in the same periods.

For my brother, an emergency room was a place to wait, questions unanswered, misinformed, anxious, but it didn't need to be. Carol Jackson and Andrew Greene, at Bethany-EHS Hospital near Chicago, converted their emergency care for adult asthmatics into the first step in a carefully designed sequence of patient and family education, evaluation, and support. Between 1992-94, returns to the ER decreased from 11.6 patients per month to 2.3, and rehospitalization rates were cut by 60%, while inpatient length of stay fell 30%.

In Terry Clemmer's ICU, careful work on improving communications with families has increased the rate of orientation of families in the ICU within 24 hours from 38% three years ago to 98% today.

What individuals have been able to achieve in areas ripe for clinical breakthrough through systematic improvement efforts has been stunning. I suggested last year that we can, if we wish, safely reduce our Cesarean section rates in this country from their current level of 23% to below 10%. Many audiences have doubted that this is possible, citing malpractice threats and patient expectations. But Dr.s Robert DeMott and Herbert Sandmire, from Bellin Hospital in Green Bay, Wisconsin, reduced C-section rates from 16.3% in 1986 to 10.4% in 1993. Dr. Charles Guise, from the obstetrics services at the U.S. Air Force Academy Hospital, reports a reduced rate from 17% in 1989 to 6% in 1993, with VBAC rates increasing from 30% to 85% in the same interval.

Improvement is within our reach. Not marginal improvement, but fundamental, breakthrough-level changes. Better for patients, families, clinicians, and payers. And yet, my father now lies in bed and will never walk again. What will it take? As a start, I suggest five changes we need:

1. CHANGE FROM INTEGRATING STRUCTURES TO INTEGRATING EXPERIENCES.

I have serious doubts as to whether the current wave of mergers, acquisitions, and reorganizations that has swept into almost every large market in health care this year will matter at all to people like my father unless the leaders so engaged ask themselves a simple question: "Why should the people of this community—those who are sick or those who may become sick—care that this change in struc ture or ownership has occurred?" The answer, if it is honest, must relate to making their experiences of care better. In my father's transition among organizations—hospital to nursing home to rehabilitation facility to house—he was in the care of five different teams of physical therapists. He had five separate evaluations, recorded on five different forms, with five different recommendations, for five separate fees. The only evident transfer of evaluation documents occurred when I drove to the hospital, picked up a copy, and carried it to the nursing home. There I was told, "We never use outside evaluations."

By contrast, integrating appointment processes in one portion of one region of Kaiser Permanente last year reduced the waiting list for well-adult appointments from 2,000 to zero in three months, while the total clinical staff required to supply those appointments fell by 4%.

2. CHANGE FROM MEASUREMENT FOR JUDGMENT TO MEASUREMENT FOR IMPROVEMENT.

The dominant use of measurement in health care systems today is what I would call "measurement for judgment." Report cards, benchmark comparisons, HEDIS, and employer based performance surveys are all inspection-based systems, seeking data on the basis of which choices can be made. It is culling, a distant second-best to real improvement. I fear the rush to information-collect ing whose main effect will be to quell aspiration and to invite dishonesty. Learning begins with curiosity, and curiosity is never totally safe.

Contrast these systems to the one Bill Nugent at Dartmouth describes as a support system for his

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team's dramatic improvements in cardiac outcomes over the past two years. Nugent writes, "By continuously tracking our outcomes, we have found it much easier to organize our selves... We needed earlier warnings of statistically real problems... We now rely on control charts... used to track input variables (e.g., patient demographics), process variables (e.g., intubation and length of stay), and outcome variables (e.g., mortality, morbidity, patient satisfaction, functional health). All this is now reported back in the form of a cardiac surgical instrument panel... In sum, I have worked to develop effective ways to collect high-quality clinical data and, more importantly, to use that data to improve outcomes."

3. MOVE BEYOND A NAIVE SEARCH FOR BEST PRACTICES, TO A MUCH HEALTHIER MODE OF "LEARNING FROM EACH OTHER."

I recently asked my daughter, Jessica, 13 years old and avid about horseback riding, whether it would help her to see a video of the Olympic gold-medalist in dressage so that she could copy her. "I'd enjoy it," said Jessica, "but it wouldn't help me much." Why? "Because what I need to learn right now isn't what she would show me."

This sensibility—seeing learning as a process, not a goal—characterizes the best improvers in health care. In reducing pressure sores by 80% at LDS Hospital, Carol Ashton did not begin by seeking the lowest rates in the nation, and then copying anything. She began by seeking knowledge, help, and insights, and by involving her own colleagues in that undertaking. Hers was a step-by step process, with infinite respect for the imagination and wisdom of the other adults with whom she worked. They looked for ideas avidly from outside their own system, but the solutions were inevitably and power fully their own. And because they were their own, they worked.

4. SHIFT OUR THINKING FROM REDUCTION OF LOCAI COST TO REDUCTION OF TOTAL COST.

The dramatic gains at Bethany Hospital in outcomes for adult asthmatics were accomplished in a resource-starved institution, treating the poorest of populations. Ask Carol Jackson how it was done, and she will begin by describing new initiatives in patient education, testing, and information systems. It will at first be impossible to understand how this inner-city hospital could possibly find the resources to improve, until you hear Ms. Jackson make the case, as she did to her own managers and clinicians, on hard facts about total costs and benefits. "We pay now," she says, "or we definitely pay later." This was the argument her team developed, supported by data inside the hospital, but it took a listening leadership able to think about now and later in the same mental breath.

I am troubled by the focus on reductions in length of stay as an end in itself. Deming warned against numerical goals, and this is one. We need to keep our minds on total costs, and it may even be that an extra day in the hospital is the best investment. We will miss that if we fail to look.

5. COMPETE AGAINST DISEASE, NOT AGAINST EACH OTHER.

We have very little to rely on nowadays other than each other. I called a hospital in Houston this year to learn about their allegedly successful innovations in pneumonia care, and was told that the gains were enormous but the methods were not to be reported in public, since excellent pneumonia care offered them local competitive advantage. No wonder people feel confused!

The enemy is disease. The competition that matters is against ill health. The purpose is healing. On my drive to work I see billboard after billboard with silly rhymes urging me to join one HMO or another, distinguishable only by their logos, and often employing the same doctors and hospitals. Every dollar of it is waste. Every beautifully printed sales brochure is care denied someone. The greatest confusion of all in this terribly confused year of market reform is that we think we will succeed by overcoming each other. My father does not care. He is in bed, with a pressure sore, staring at a wheelchair he does not need, and living with the undeserved memory of insult, delay, and medically induced coma.

I propose that we take aim where it matters. Pressure sores are the enemy. Stop them. Errors in drug use are the enemy. Stop them. Fragmentation is the enemy. It creates waste, cost, and disrespect. Stop it. If we cannot work together on improvements that matter to the people who call upon us for help, then I reject your restructuring, I dismiss your mergers, I doubt your integrated system, I deplore your report card. It was my father this time, but next time, it will be your father, and then you, and then your child. I have heard it said by cynics that the quality of medical care would be far better and the hazards far less if doctors, like pilots, were passengers in their own airplanes. We are. ■

Reprinted from Quality Connection, Winter 1995.

Carmen Buell: Chair, Committee on Health Care

Carmen Buell, state representative for the Second Franklin District, addressed the annual meeting of the HDMS April 25, 1995. She has been House Chair of the Legislature's Joint Committee on Health Care since January, 1991. She has a masters degree in regional planning. she has subsequently revealed that she is planning to resign her seat July 1, 1995 to join her husband Michael Hooker who is becoming Chancellor of the University of North Carolina. She has expressed interest in a new career in health care or as an athletic director. A summary of her remarks is given below.

I would like to discuss three areas tonight. I want to discuss what the blue ribbon commission on health care reform is going to be doing and to discuss the implications of the new federally approved Medicaid waiver for Massachusetts. I want to discuss the physician disclosure bill, for which I'm the lead sponsor. Lastly I'll discuss the fast moving market changes that are happening. We were actually anticipating a comprehensive health care reform at the national level. That didn't happen last fall. With no federal plan to respond to, we were also confronting the timed date of the employer mandate that was passed in 1988. We didn't have enough time left in our session to respond with a state comprehensive plan or to deal with any kind of implementation of an employer mandate. So we established a special blue ribbon commission to look at the issues of health care reform. We postponed the implementation of the employer mandate until January 1, 1996. At the same time, the Weld administration had filed with the Federal Government a demonstration waiver for Medicaid. Weld is unequivocably opposed to any kind of employer mandate. The waiver was Weld's approach to meeting the goal of moving toward universal coverage and expanding access. HCFA finally approved the waiver with 74 conditions. The waiver increases the eligibility for Medicaid for children, pregnant women, and the disabled to 133% of the poverty level for income. The second part of the waiver is to develop an insurance product that makes it easier for employers to contribute. Weld has proposed a tax credit for a 50% contribution by employers towards an employee's health insurance premium. The state would design a basic benefit package that these employees could purchase. In addition a subsidy will be available to certain low income workers to assist in purchasing health insurance. Where will this money come from? The plan is to use the uncompensated care pool. Many hospitals and others have said this is unfair. I agree, but since we are not going to be involved in raising broad based revenues, that is the only pot of money that is available. The waiver will be the cornerstone of the work of the commission. Because of the delay in the granting of the waiver and the reporting deadline for the commission of September 1995, the commission will not have time to tackle other issues beyond the waiver. The other work of the commission will be to continue on with insurance market reform to make products more affordable. I had hoped that the commission could take a broader look at the market but I don't think that will be possible.

We were actually anticipating a comprehensive health care reform at the national level.

The physician disclosure bill is a controversial one for the Society to say the least. This is potentially one of those issues that captures the public's taste for sensationalism. Most of the rhetoric involved in this has nothing to do with good

medical practice. The bill that the MMS has proposed recognizes that there is going to be a demand for information about physicians and that we should do it in a reasonable manner and a responsible way. When I talk to advocacy groups who want very broad disclosure, I ask them, "How do you know what people want to know when they choose a physician?" Recent national focus groups suggest that what people actually want to know is not what the advocacy groups are pushing for. What they want to know is, "Will the physician have time to listen to me? Will the physician care about what's bothering me?" The MMS bill strikes a very good balance I believe. I hope that those of you who don't support this bill realize that if a step isn't taken that is rational and reasonable the pressure will be there to do something extreme that is harmful. I applaud the MMS for being ahead of the curve on this.

Finally I want to talk about market climate. Managed care in Massachusetts is not going to go away. We have perhaps the highest penetration of managed care and it's going to increase. The Republicans have now "discovered" health care and feel they have to deal with it since they're in power now. They're looking at putting Medicare recipients in managed care. Whether it's going to work or not is not the issue. I have very serious questions about what we will be looking at five to ten years from now. Will we say, "How come we didn't monitor what was going on and intervene from the public's point of view?" We need to make sure we have responsible, caring providers that are in settings where people will go. My greatest fear is that when these networks are established, you won't be able to get care in your own community. I encourage you to provide input about how government can oversee and regulate these market changes so managed care will work for everyone in Massachusetts because it's not going to go away. Make sure you participate with us so we have a system that provides care to everyone and improves health status.

Representative Buell then answered a series of questions from the audience. A question about the limitations of coverage of Medicare, including lack of coverage of prescriptions and preventive care, was stated to be a federal issue. Ms. Buell stated that 85% of the non-elderly Medicaid recipients are now in some form of managed care. Medicaid has its own managed care program with the P.C.C. system or the patients

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can choose an established HMO. This program has been estimated to have saved 20 million dollars over the past several years and the rate of growth of Medicaid has decreased to 4% from 20%. Ms. Buell pointed out that 75% of the Medicaid budget goes to the elderly and disabled for long term care.

Employers or purchasers of health care insurance have recently realized their leverage in the current situation. They want their employees to be happy. The patients need to communicate their dissatisfactions to their employers with the health care plans they have. But doctors have to become more aggressive. Hospitals are going to be minor players as these networks emerge according to Ms. Buell. The idea of physicians being the drivers of the system is something we all need to embrace. It's out there for the taking in Ms. Buell's view.

Ms. Buell stated that government cannot address the burgeoning paperwork crisis in HMO medicine. Ms. Buell supports a reappraisal of anti-trust regulation so as not to impede the development of a physician driven system but she feels that the Clinton administration is very "unflexible" in this area. She is opposed to any willing provider legislation which she pointed out includes chiropractors, marriage counselors and others. She feels that public demands for "perfect" medicine and "death as an option" are irrational, but that the physician disclosure bill is pragmatically necessary. ■

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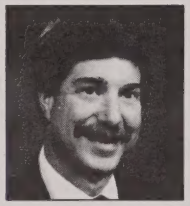

Attorney
Arthur W. Price

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ATTORNEYS AT LAW

One Monarch Place, Suite 1300, Springfield, MA 01144-0001
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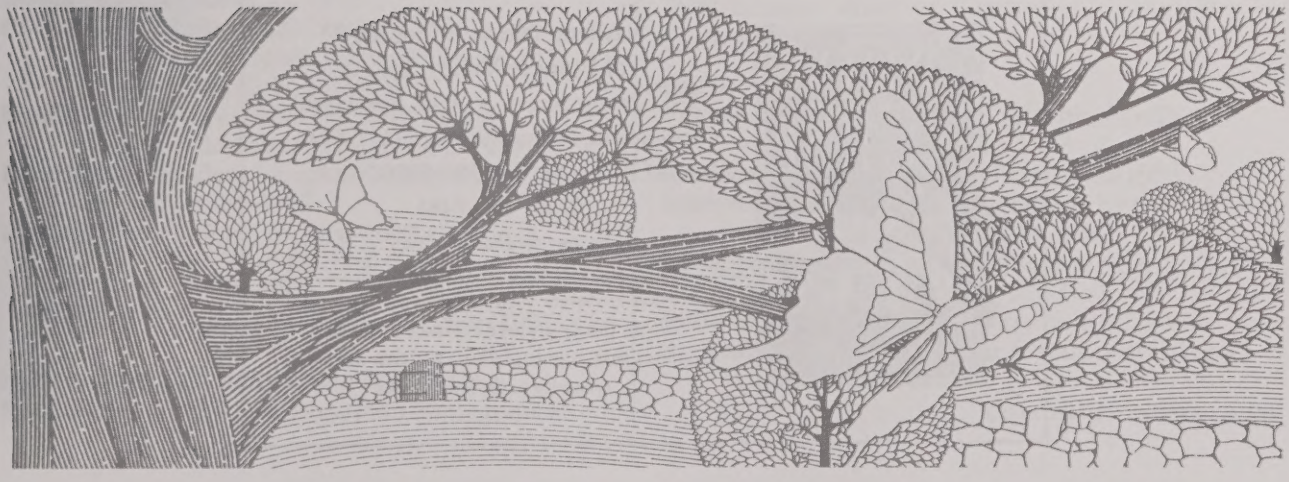
MMS Executive Briefs

At its Annual Meeting on May 19, the MMS House of Delegates approved new policy concerning physician-assisted suicide, reaffirmed existing policy on pluralistic financing of health care delivery, and expanded the Society's current violence prevention program. The House of Delegates met over two days in Boston to consider more than 30 resolutions and reports on a wide variety of subjects. After nearly three hours of reference committee testimony on the merits of single payer versus pluralistic financing for health care, the House voted to reaffirm the Society's support for "pluralistic financing to achieve universal access and coverage." The House also directed the Board of Trustees to conduct a study of existing single-payer systems in comparison to the existing pluralistic financing mechanisms in Massachusetts. This Board report will be submitted to the House for its 1996 Annual Meeting.

In other policy decisions, the MMS House of Delegates voted to oppose physician-assisted suicide; the House reinforced this new policy by also voting to provide physicians with "the legal, social, ethical, and medical education, training, and resources" to better treat and counsel terminally ill patients. (In April, the Society had testified against the physician assisted suicide bill, House 3173, "An Act to Allow Death With Dignity." The legislature's Joint Committee on Health Care sent the bill to study in early May, effectively ending debate on the measure for this legislative session.)

The House also voted to expand the Society's ongoing *campaign against violence* by funding new educational resources for physicians and patients. The House took the action in response to a confidential survey of MMS members (thought to be the first of its kind at the state medical society level) concerning violence in their lives. Nearly 65 percent of respondents said they had encountered cases of spousal or partner abuse in their practices, and a majority of respondents also said new educational materials and professional services related to violence were needed. The Society's current campaign on violence, which has received state and national recognition, has included the distribution of educational materials to help physicians better treat victims of violence. Among other votes by the House of Delegates:

Health Care Proxy Education Project: the



House approved this resolution, which calls on the Society to work with hospitals, medical schools, and other organizations on educational materials for physicians and patients. to improve knowledge and use of health care proxies.

Injustice of Medicare Contracting: in approving this resolution, the House called on the Society to work with the Massachusetts Congressional delegation and the Health Care Financing Administration to seek changes in federal Medicare law that would require standardization of Medicare benefits and standards for all patients and physician providers.

Mandatory HIV Premarital Testing: the House voted to continue MMS opposition to mandatory HIV premarital testing. This resolution was initially considered by the House at its 1994 Interim Meeting, and then referred to the Board of Trustees for further study and reconsideration by the House this year.

Assault Weapons: the House approved this resolution, which calls on the Society to support a statewide ban on the sale or possession of assault weapons by private citizens.

Promutual Receives License; New Directors Named

On May 3, 1995, the *Massachusetts Medical Professional Insurance Association* (MMPIA) received its license from the Division of Insurance to do business as a mutual insurance company. The new company, officially called the Medical Professional Mutual Insurance Company, will be known as ProMutual. As a mutual company, ProMutual is owned by its policyholders, including physicians, hospitals, nurse-midwives, and other health providers. At its first board of directors meeting on May 3, Francis X. VanHouten, M.D. and Erwin A. Stuebner, Jr., M.D., were elected to fill new physician director positions on the Board. Kenneth A. Heisler, M.D. and Henry M. Lerner, M.D. were both re-elected to the ProMutual board, which now has a physician majority (seven of thirteen positions).

MMS Officers Elected

Guenter L. Spanknebel, M.D., a gastroenterologist who practices in Worcester, was elected president of the Massachusetts Medical Society May 19 at the MMS Annual Meeting. Doctor Spanknebel, chief of gastroenterology and director of continuing medical education at the Medical Center of Central Massachusetts, is the first international medical school graduate to become MMS president. Other officers elected for 1995-96 at the Society's Annual Meeting include: Joseph M. Heyman, M.D., a West Newbury obstetrician-gynecologist and President of Women's Health Care as MMS president-elect; Allan H. Goroll, M.D., F.A.C.P., an internist at Massachusetts General Hospital, as vice president; Marylou Buyse, M.D., secretary-treasurer; Charles A. Welch, M.D.; assistant secretary-treasurer; Asha P. Wallace, M.D.; speaker; Alan M. Harvey, M.D., vice speaker; Grant V. Rodkey, M.D., orator. ■

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New Members Welcome

Stuart D. Haraway, M.D.
444 Montgomery Street
Chicopee, MA 01020

Born: April 3, 1963
Premed: University of Oklahoma 1981-1985
Medical: University of Oklahoma College of Medicine 1985-1989
Internship: Oklahoma Memorial Hospital 1989-1990
Residency: Oklahoma Memorial Hospital 1990-1993
Specialty: Obstetrics/Gynecology

Alison E. MacDonald, D.O.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 25, 1961
Premed: Bates College, Maine 1979-1983
Medical: Philadelphia College of Osteopathic Medicine 1986-1990
Internship: St. Joseph's Hospital, Pennsylvania 1990-1991
Residency: Baystate Medical Center 1991-1994
Specialty: Anesthesiology

Rafael A. Rodriguez, M.D.
Springfield Anesthesia Service
P.O. Box 1330
Springfield, MA 01101

Born: October 11, 1952
Premed: Universidad Nacional Pedro Henriguez Urena, Dominican Republic 1969-1972
Medical: Universidad Nacional Pedro Henriguez Urena 1972-1977
Internship: Harlem Hospital Center, New York 1986-1987
Residency: Harlem Hospital 1987-1989
New York Medical College (Valhalla) 1989-1991
Children Hospital of Buffalo 1991-1992
Fellowship: Cleveland Clinic 1992-1993
Specialty: Anesthesiology/Pain Management

William T. McGee, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: May 23, 1957
Premed: Dartmouth College, New Hampshire 1979
Medical: New York Medical College, Valhalla, New York 1983
Residency: Baystate Medical Center 1986
Fellowship: St. Louis University/St. John's Mercy Medical Center 1986-1988
Specialty: Internal Medicine/Critical Care

Gregory L. Gardner, D.O.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 19, 1965
Premed: St. Lawrence University 1983-1987
Medical: New York College of Osteopathic Medicine 1988-1992
Internship: Medical Center Hospital of Vermont, University of Vermont College of Medicine 1992-1993
Residency: Baystate Medical Center 1993-Present
Specialty: Anesthesiology
Resident

G. Glenn Kabell, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: May 23, 1950
Premed: University of California, San Diego and Berkeley 1973
Medical: University of Miami 1980-1982
Internship: Dartmouth-Hitchcock, New Hampshire 1982-1983
Residency: Dartmouth-Hitchcock, New Hampshire 1983-1985
Fellowship: University of Virginia 1985-1987
Specialty: Clinical Cardiac Electrophysiology

Continued on next page

New Members Welcome

Continued from previous page

Greg Wolff, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: June 24, 1964
Premed: Hunter College, New York 1986-1990
Medical: State University of New York at Stonybrook 1990-1994
Internship: Baystate Medical Center 1994-1995
Specialty: Internal Medicine
Intern

Jere L. Ponder, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: April 30, 1954
Premed: California State University, Los Angeles 1988
Medical: Loyola University-Stritch School of Medicine, Illinois 1988-1992
Internship: Baystate Medical Center 1992-1993
Residency: Baystate Medical Center 1993-1995
Specialty: Internal Medicine
Resident

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ANNOUNCEMENT

The Springfield Vet Center is recruiting any in-country Persian Gulf, Somalian, and Women Veterans, as well as their families (and significant others) who are in need of our services.

The Vet Center provides a range of services to help Veterans who served during the Vietnam Era (5 August 1964 to 7 May 1975), in Lebanon (25 August 1982 to 26 February 1984), in Grenada (23 October 1983 to 21 November 1983), in Panama (20 December 1989 to 31 January 1990), in the Persian Gulf (2 August 1990 to –), and in Somalia (17 September 1992 to –).

The counseling services provided are individual, couple, family and group therapy for veterans and families who are experiencing difficulties related to readjustment from military to civilian life.

Other outreach counseling services are:

2. Dr. Merrideth McCarran, Ph.D., Psychologist, is here on Tuesday afternoons, providing vocational/rehabilitation testing and counselling.

3. Referrals are made to Garrett Gartska, Veterans' Affairs Outpatient Clinic, Federal Building, 1550 Main Street, Springfield, MA. The Outpatient Clinic is just a 5 minute walk from the Vet Center.

4. Stephen Dowd, DVOP, Department of Employment and Training, Springfield, MA., will provide job referral/placement services on Wednesdays from 9:00 a.m.–12:00 p.m. by appointment.

The Vet Center also provides agent Orange information, medical referrals, discharge upgrade information, community referrals, community presentations (films, speakers), and follow-up to ensure adequacy of services. The Center is located in Springfield at Northgate Plaza, 1985 Main Street, (413) 737-5167 or 1-800-843-8444. ■

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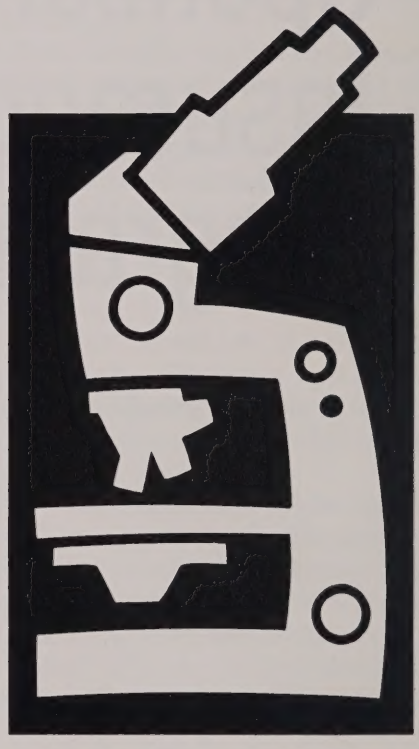

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